STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	05/11/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

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F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification Survey, Civil Rights Compliance Survey, State Licensure Survey and an Abbreviated survey in response to a complaint, completed on May 11, 2023, it was determined that Wyndmoor Hills Rehabilitation ans Nursing Center, was not in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.	F 0000		
F 0585 SS=D		F 0585		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0585 SS=D	Continued from page 1 483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 0585	1. The Activities Director held a special resident council on Thursday May 11, 2023 to educate R12, R43, R47, R106, and R18 regarding grievances 2. The Activities Director/designee held a scheduled resident council meeting on May 23, 2023 and one of the topics was grievances. 3. Grievance forms were placed in the 2nd and Third Floor grievance boxes. IDT Team will be in-serviced regarding the grievance policy and procedure by the NHA/designee. 4. NHA/designee will audit grievance forms weekly x4 and monthly x2 to ensure there are blanks in the boxes. The results of audits will be reported to the QAPI Committee monthly x3 months for further review and recommendations.	Completion Date: **07/10/2023** Status: **APPROVED** Date: **06/01/2023**

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F 0585 SS=D	Continued from page 2 can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the	F 0585		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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F 0585 SS=D	Continued from page 3 date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: [illegible]	F 0585		

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F 0623 SS=D		F 0623		

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F 0623 SS=D	Continued from page 5 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	1. R12 and R48, or their family will be provided notice of discharge to the hospital with the contact and address of the Office of the State Long Term Care Ombudsman. 2. Current Resident with discharge to the hospital in the last 30 days will be reviewed by the NHA/designee for evidence of providing the resident or resident representative in writing of the discharge to the hospital and providing notification of the discharge to the Office of the State Long Term Care Ombudsman. 3. IDT Team and Licensed Nurses will be inserviced by the NHA Designee on the Notice of Transfer and Discharge Policy and Procedure. Residents and/or the resident's representative and the Office of the State Long Term Care Ombudsman will be notified of discharges to the hospital. A discharge and transfer log will be implemented to be utilized for proper notification to the Office of the State of the Long Term Care Ombudsman. 4. An audit will be conducted by	Completion Date: **07/10/2023** Status: **APPROVED** Date: **06/01/2023**

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F 0623 SS=D	Continued from page 6 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623	the NHA/designee for weekly x 4 and monthly x2 of resident's who were discharged to the hospital to ensure the resident or resident's representative and the Office of the State Long Term Care Ombudsman were provided with a notice of transfer and discharge to the hospital. Results of the audits will be reported to the QAPI Committee monthly x3 months for review and recommendations.	

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F 0623 SS=D	Continued from page 7 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 0623		

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F 0623 SS=D	Continued from page 8 [illegible]	F 0623		
F 0656 SS=D	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 0656	F0656 Development of Comprehensive Care Plans 1. R20's care plan and regarding the BIPAP was developed 2. A review of current residents care plans with BIPAPs was conducted by the DON/designee for development and implementation by the DON/designee 3. Licensed Nurses will be inserviced by the DON/designee regarding the care plan development policy and procedure. 4. An audit will be conducted by the DON/Designee weekly x4 and monthly x2 on care plans to ensure there is a care plan developed for residents with BIPAPs. Results of the audits will be reported to QAPI x3 months for review and further recommendations	Completion Date: **07/10/2023** Status: **APPROVED** Date: **06/01/2023**

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F 0656 SS=D	Continued from page 9 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	Continued from page 10 Based on observations, a review of the clinical record and interviews with staff, it was determined that the facility did not ensure that a comprehensive person-centered care plan with measurable objectives and goals was developed and implemented for one of 17 residents reviewed related to oxygen and CPCP machine usage (Resident R1). Findings include: Observations of Room 223 on May 8, 2023, at 11:45 a.m. revealed Resident R20 sitting in her wheelchair wearing a nasal cannula (plastic tubing designed to deliver oxygen directly into the nose) with long tubing connected to an oxygen concentrator next to her bed. Also on her bedside table was her BIPAP (a type of ventilator used to treat chronic conditions that affect your breathing, similar to a CPAP machine, but unlike a CPAP, which delivers a continuous level of air pressure, a BPAP delivers two levels of air pressure) machine with tubing and a mask.	F 0656		

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F 0656 SS=D	Continued from page 11 Interview with Resident R20 on May 8, 2023, at 11:45 a.m. revealed that she required the oxygen continuously, and that she used her BIPAP machine every night to help her sleep. Review of Resident R20's clinical record revealed the resident was admitted to the facility on February 16, 2023, with diagnosis including but were not limited to obstructive sleep apnea (OSA is a disorder that makes you stop breathing repeatedly during sleep, depriving your body and brain of oxygen). Further review of Resident R20's clinical record revealed a February 16, 2023, physician's order for oxygen (02) at 3-4 liters/min via nasal cannula every shift for SOB (shortness of breath). Further review revealed a February 16, 2023, physicians order for BIPAP with settings of 20/7 every evening and night shift for OSA. A review of Resident R20's care plan revealed no	F 0656		

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F 0656 SS=D	Continued from page 12 interventions related to the resident's use of oxygen or a BIPAP machine as a therapy to treat her OSA and SOB. Interview with the Director of Nursing, on May 10, 2023, at 2:30 p.m. confirmed that the Resident R20 required continuous oxygen, and that she uses a BIPAP machine to sleep and that the facility had not developed or implemented a care plan for these interventions. 28 Pa. Code 211.11(a)(b)(c) Resident care plan 28 Pa. Code 211.11(d) Resident care plan	F 0656		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 13 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	F0657 Care Plan Timing and Revisions 1. R 34's care plan was revised by the Dietitian 05/11/2023. 2. Current residents care plans were reviewed by the Dietitian related to weight gain/loss to ensure they were revised timely. 3. Dietitian will be inserviced regarding timely revision of resident's weight gain/loss care plans 4. An audit will be conducted by DON/designee weekly x 4 weeks and monthly x2 to ensure weight loss/gain care plans are being revised timely. Results of the audits will be reported to QAPI monthly x 3 months for further review and recommendations	Completion Date: **07/10/2023** Status: **APPROVED** Date: **06/01/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	05/11/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

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F 0657 SS=D	Continued from page 14 Based on review of facility documentation and staff interview, it was determined that the facility did not review and revise a care plan related to weight loss for one of 17 records reviewed (Resident R34). Findings include: Review of Resident R34's plan of care revealed that a focus area dated November 23, 2022 addressed resident as having an Activities of Daily Living self-care deficit related to activity intolerance and obesity. Resident R34 has had a significant weight loss and now receives Remeron and supplemental shakes. Interview on May 10, 2023 at 2:00 p.m. with the Director of Nursing, confirmed that Resident R34 care plan was not updated to accurately reflect the resident weight loss. Resident R34's care plan continued to identify resident as obese. 28 Pa. Code 211.11(a)(b)(c) Resident care plan	F 0657		

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F 0657 SS=D	Continued from page 15 28 Pa. Code 211.11(d) Resident care plan	F 0657		
F 0690 SS=D	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based	F 0690	1. Resident # 48's catheter connector was placed by licensed nursing staff on Thursday May 11, 2023 2. Current residents with catheters were reviewed by the DON/designee to ensure the correct catheter supplies are available. 3. Licensed Nurses were will be inserviced on the catheter policy and procedure. Catheter supplies for residents with catheters will be placed in each resident's room. 4. Audits of resident rooms with catheter supplies will be conducted weekly x4 then monthly x2 by the DON/designee to ensure catheter supplies are in resident's rooms. Results of the audits will be reported to QAPI monthly x 3 months for further review and recommendations	Completion Date: **07/10/2023** Status: **APPROVED** Date: **06/01/2023**

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F 0690 SS=D	Continued from page 16 on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 0690		

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F 0690 SS=D	Continued from page 17 Based on clinical record review, review of facility policy and staff interviews, it was determined that the facility failed to ensure that the proper connector piece was available for a suprapubic urinary catheter for one of one resident observed with an urinary catheter. (Resident R48)\ Finding include: Review of facility policy, Urinary Catheter Care, revised September 2014, revealed: The purpose of this procedure is to prevent catheter-associated urinary tract infections. General Guidelines: 2. If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment, as ordered. Observation during medication administration on May 10, 2023 at 9:15 a.m. with Employee E4, licensed nurse, revealed a strong odor of urine in	F 0690		

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F 0690 SS=D	Continued from page 18 Resident R48's room. Resident R48 was observed in his bed completing his breakfast when Employee E4 approached with medication. Urine was observed on the floor and a urine collection bag was observed in a pink basin on the floor. Upon exiting Resident R48's room after medication administration, Employee E4 called for housekeeping to come mop the floor. The observation was reported to Employee E2, Director of Nursing. Employee E2 confirmed that Resident R48 has a suprapubic urinary catheter and the collection bag was leaking. The suprapubic collection bag was different and not compatible with the foley catheter collection bag. Employee E4 placed an order for a connector piece to make the suprapubic urinary catheter collection bag compatible with the foley catheter collection bag. During interview it was revealed that it took one week for the connector piece to arrive. The suprapubic catheter collection bag drained urine into a pink basin on the floor for one week.	F 0690		

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F 0690 SS=D	Continued from page 19 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services	F 0690		
F 0812 SS=F		F 0812		

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F 0812 SS=F	Continued from page 20 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. No specific residents were cited in this F-Tag 2. The cardboard boxes and lids were broken down and lid closed, the floor drain and walls were cleaned, Walk in refrigerator will be cleaned, space will be covered and flush so it can be cleaned, Walk in Freezer plastic strip was missing will be replaced. Refrigeration vendor will be called for the flush. Tiles near kitchen doorway were cleaned, pipe leading to skink will be replaced. Sink will be replaced. Ceiling tiles will be cleaned or replaced. Bag with fried eggs was tied and plastic jug was thrown away. The garbage disposal will be removed and the plastic lens/guard for light will be installed. The test strips were obtained on May 11, 2023 and the chlorine was tested to be within normal limits. 3. Dietary and Maintenance Staff will be inserviced regarding sanitary conditions policy and procedure. Dietary staff will be inserviced regarding chlorine testing of rinse water to ensure proper	Completion Date: **07/10/2023** Status: **APPROVED** Date: **06/01/2023**

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F 0812 SS=F	Continued from page 21	F 0812	sanitization of dishes. 4. Dietary Manager/designee will conduct a sanitation audit weekly x4 then monthly x2. The audits will be forwarded to QAPI for further review and recommendations. Dietary Manager will conduct an audit weekly x4 and monthly x2 of dish sanitization log and test strips to ensure proper sanitization of dishes. Results of the audits will be reported to QAPI x 3 months for further review and recommendations.	

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F 0812 SS=F	Continued from page 22 Based on observations and interviews with staff, it was determined that the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. Findings include: An initial tour of the Food Service Department was conducted on May 8, 2023, at 10:30 a.m. with Employee E3, Food Service Director (FSD), which revealed the following: Observation in the receiving area revealed a green dumpster with the lids open and cardboard boxes sticking out the top, and eight wooden pallets stacked up behind the dumpster. Observation in the mop closet area near the receiving door revealed a thick build-up of black substance in the floor drain area and the walls were splashed with dark substance.	F 0812		

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F 0812 SS=F	Continued from page 23 Observation in the walk-in refrigerator Box 1 revealed a metal piece along the floor and wall which was corroded and lose causing sharp edge and creating space that is not able to be cleaned and sanitized. Further observation revealed a cardboard box containing fried eggs which was open to the air, and a gallon size plastic jug that was not labeled or dated and was covered in a black substance and contained garlic. Observation in the walk-in freezer revealed one plastic strip in the door was missing and there was a buildup of frost and ice around the door opening. Observation of the floors in the kitchen near the doorway revealed a large rust/brown colored stain on the floor tiles. Observation in the three-compartment sink area revealed a scrap sink with standing water as the drain was clogged and the garbage disposal was not working, and a florescent ceiling light that was missing the plastic lens/guard.	F 0812		

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F 0812 SS=F	Continued from page 24 Observations in the back kitchen area revealed black soot on the ceiling tiles. Interview with FSD on May 8, 2023 at 11:00 a.m. confirmed the above findings and that the ceiling tiles were black from a grease fire in the kitchen, and that the all food in the walk-in cooler should be covered, dated and labeled. Observations during a follow up visit to the kitchen on May 10, 2023 at 1:52 p.m. to observe dish machine revealed a wash temperature of 100 degrees. An interview with the FSD revealed that the dish machine was a low temp, sanitizing machine. When asked to test the concentration of the sanitizer, she stated that they do not have test strips for chlorine. She confirmed that she was not able to test the rinse water to ensure that the dishes were properly sanitized. 28 Pa. Code: 201.14(a) Responsibility of licensee.	F 0812		

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F 0812 SS=F	Continued from page 25 28 Pa. Code: 201.18(e)(1) Management. 28 Pa. Code 201.18(b)(3) Management	F 0812		
F 0880 SS=E		F 0880		

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F 0880 SS=E	Continued from page 26 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	1. Employee 1 was inserviced regarding proper infection control practices when providing wound care treatments. No specific residents were cited regarding the water policy and procedure as it relates to legionella testing. 2. Wound Care Observations for current residents with wounds will be completed by the DON/designee with the Licensed Nurses Legionella kits were obtained and a sample will be collected by the Maintenance Director/designee. The sample will be sent on 06/02/2023 3. Licensed Nurses will be inserviced by the Director of Nursing/designee regarding the Infection Control Policy and Procedure related to wound care treatments. A policy and procedure was developed for regular testing of water related to legionella . The Maintenance Director will be in	Completion Date: **07/10/2023** Status: **APPROVED** Date: **06/01/2023**

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F 0880 SS=E	Continued from page 27 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	serviced by NHA/designee on the water testing for legionella policy and procedure. 4. Random wound care observations will be conducted by the DON/designee weekly x4 then monthly x2 to ensure proper infection control procedures are being implemented. NHA/designee will audit to ensure Legionella testing is being performed and results are being returned to the facility. Results of the audits and observations will be reviewed by the QAPI Committee monthly x 3 months for further review and recommendations.	

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F 0880 SS=E	Continued from page 28 [redacted] 28 Pa. Code 211.12 (a)(b)(3)(c) Nursing Services	F 0880		
F 0921 SS=E		F 0921		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0921 SS=E	Continued from page 29 483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 0921	1. The broken dressers or drawer for 316 and 317 were repaired on 5/11/2023 2. A review of the 3rd floor rooms will be conducted by the NHA/designee and any broken dressers and/or drawers will be repaired by the Maintenance Director/designee. A stripping and waxing project was being conducted during the survey by Housekeeping. The project is currently ongoing. 3. The Maintenance Director and Housekeeping Director will be inserviced on the Maintenance Policy and Procedure. 4. An audit of dressing and drawers will be completed weekly x4 then monthly x2 by the NHA/designee. A review of the stripping and waxing project on third floor will be completed by the NHA/designee. Results of the audits will be reported to QAPI monthly x 3 months for review and any recommendations for follow-up.	Completion Date: **07/10/2023** Status: **APPROVED** Date: **06/01/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	05/11/2023

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STATE LICENSE NUMBER: **21610201**	

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F 0921 SS=E	Continued from page 30 Based on [illegible] 28 Pa. Code 207.2(a) Administrator's responsibility	F 0921		
F 0925 SS=E		F 0925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0925 SS=E	Continued from page 31 483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 0925	1. Rooms 202-236 windows were closed on May 10, 2023 2. A tour of facility was made and remainder of open windows were closed on May 10, 2023. An exterior round of the facility will be made to identify the location of exterior openings. 3. Windows to the facility will be kept closed. A window vendor will be contacted by the NHA/designee for an assessment of replacement screens. Facility staff will be inserviced regarding keeping windows to the facility closed. The exterior openings identified will be repaired by the Maintenance Director. The Housekeeping and Maintenance Director will be inserviced by the NHA/designee regarding the pest control program policy and procedure. 4. A random audit of the resident room windows will be conducted by the NHA/designee to ensure they are kept closed to prevent pests weekly x4 and monthly x2. The results of the audits and progress of repairs to the exterior openings will	Completion Date: **07/10/2023** Status: **APPROVED** Date: **06/01/2023**

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F 0925 SS=E	Continued from page 32	F 0925	be reported to QAPI monthly x3 months for further review and recommendations for follow-up.	

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F 0925 SS=E	Continued from page 33 Based on observations, staff interviews and a review of facility policies and documentation, it was determined that the facility was not maintaining an effective pest control program. Findings include: A review of the undated facility "Pest Control" policy revealed that it states that the facility will maintain an on-going pest control program to ensure that the building is kept free of insects and rodents. Observations during a tour of the facility on May 8, 2023, at 10:45 a.m. in room 203 revealed small flies buzzing around the room and further observation revealed that the window was being held open with a urinal stuck in the bottom of the window and that there was no screen in the window. Observation in room 223 on May 10, 2023, at 1:15 p.m revealed a fly in the room and the window was open with no screen. Further observation down two of three hallways on the second floor that the	F 0925		

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F 0925 SS=E	Continued from page 34 windows were open in all rooms from room 202 to room 226 and that none of these open windows had screens. Observations in the laundry area on the first floor on May 10, 2023, at 1:35 p.m revealed a large overhead garage door which was wide open to the outside of the building and all of the doors leading to this area were also open. An interview on May 10, 2023, at 1:50 p.m., with the Nursing Home Administrator, revealed that the facility had regular visits from a pest control company, and he provided reports from the company, and he acknowledged that there were windows and doors open in the facility. A review of the pest control company's reports revealed that on April 17, 2023, they recommended replacing screens to help reduce insect activity inside; on March 6, 2023, they recommended shutting unscreened windows; March 17, 2023, they recommended the many openings on the	F 0925		

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F 0925 SS=E	Continued from page 35 exterior of the building remain, and that if these openings are not addressed pasts will certainly enter the building in high numbers, and that if there are not squirrels and raccoons inside the building already you are very lucky; April 17, 2023, they indicated that none of the recommended exterior repairs have been made to date including open windows with vines in them and that screens should be on all windows; April 24, 2023, they recommended shutting the windows including ones with vines growing inside. 28 Pa. Code 207.2(a) Administrator's responsibility 28 Pa. Code 201.18(a)(b)(1)(3) Management	F 0925		

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P 2020	§ 211.12(i) Nursing services. (i) A minimum number of general nursing care hours shall be provided for each 24-hour period. The total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 2.7 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 2020	1. No specific residents were cited for this state only deficiency 2. In review of the nursing deployment sheets, the actual PPDs were above a 2.7 not the projected PPDs cited in this deficiency and forwarded to surveyor on May 15, 2023 3. NHA, DON, and HR will be inserviced regarding the current and future minimum staffing requirements. NHA, DON, and HR will meet to review schedules for next day to ensure staffing requirements are met. 4. NHA/designee will audit daily staffing schedules to ensure minimum staffing requirements 4 weeks then monthly x2 months. The results of the audits will be reported QAPI monthly x 3months for further review and recommendations.	Completion Date: **07/10/2023** Status: **APPROVED** Date: **06/01/2023**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 2020	Continued from page 1 Based on a review of facility nursing staffing schedules and interview with employees, it was determined that the facility failed to meet the minimum number of general nursing care hours for each 24-hour period for three of five days reviewed. (May 7, 2023, May 9, 2023 and May 10, 2023) Findings include: A review of nursing schedules from May 4, 2023, through May 10, 2023, revealed that the facility failed to meet the minimum number of general nursing hours of 2.7 hours of direct resident care for each resident on five of seven days reviewed as follows: Sunday, May 7, 2023, was 2.62 hours of direct resident care. Tuesday, May 9, 2023, was 2.67 hours of direct resident care. Wednesday, May 10, 2023, was 2.67 hours of direct resident care.	P 2020		

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P 2020	Continued from page 2 During a telephone interview with the Director of Nursing on May 15, 2023, at 2:00 p.m. she acknowledged that the facility did not meet the state requirement of 2.7 hours of direct resident care for each resident on the three dates above. 28 Pa. Code 211.12(i) Nursing services 28 Pa. Code 211.12(i) Nursing services	P 2020		

Certified End Page

WYNDMOOR HILLS REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 21610201

SURVEY EXIT DATE: 05/11/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY